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SCIENCE, PSYCHIATRY AND SOCIAL JUSTICE

De-Meaning Psychotherapy: The New Psychiatric Critic

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Editor's Note: This article is being simultaneously published on our affiliate site, Mad in the UK. It was written by Jan Sheppard, an existential individual, couple and family therapist.

Most of my life has been occupied with understanding the destruction inflicted on me and members of my family by psychiatry. In 1990 aged 18 I was diagnosed a borderline-case paranoid-schizophrenic. I was diagnosed in the USA so effectively I went mad in America. My life came to a stop. The diagnosing psychiatrist, on the other hand, went on to write best sellers ultimately appearing on Oprah.

In 1995 I began training as an existential-phenomenological psychotherapist in London. There was no relationship between these two events. I did not train in order to make sense of what had happened to me. I assumed this to be impossible not only for me but for anyone. I had imbibed the common myth that psychotherapy is subsidiary to the field of psychiatry. One can only reach a certain level of understanding of distress and then a psychiatrist must be called in.

I learnt the opposite to be the case and I re-learn it over and over again in my work. This paper is an honest summary of my current point of view. True, it is written through a largely professional and theoretical lens. Nonetheless, it expresses ideas that have helped me personally over the years to return to myself and to help others who have been dragged through the psychiatric mill to do the same. It is a distillation of my personal and professional history of thirty-five years, twenty-five of which I have worked as an independent existential individual, couple and family psychotherapist. I have worked in residential psychiatric settings, four NHS outpatients clinics and taught and supervised at some of the most prestigious colleges in the UK.

I reject psychiatry. But I also reject the critic. In this paper I explain why and offer an alternative. I argue that in the final analysis psychiatric abolition must be a deeply personal act.

Anyone can see through the lies of psychiatry. With a little courage, it is possible to progress through three rough stages of a) critiquing, b) rejecting and c) calling for the abolition of psychiatry.

However, detailed descriptions of psychiatric self-emancipation by non-professionals and professionals alike are comparatively rare. On the one hand, most non-professionals who have been through the psychiatric mill are only too happy to be left alone and walk away from psychiatry. For this reason we tend not to hear from them. On the other, the professional – especially the psychotherapist – is expected to proceed in the diametrically opposite direction; the more he trains, the longer his personal analysis and the greater his professional recognition, the more his personal-professional identity is expected to become fused with that of the psychiatrist.

I surmise that the ordinary person is in touch with a fundamental principle of the profession of psychotherapy in a way that the seasoned professional often is not. Put simply, this foundational rule dictates one must start with oneself not theory, seminars, technique or scholarly activity of any sort. One must first purify one's own psychiatric air if one is to help others do the same. For example, British existential analyst Aaron Esterson wrote:

> *'Of course, to merit the respect of the traveller the guide must himself be a pilgrim speaking from his own experience. He is not a sign-post pointing the way for others while he sits at home consulting the book of rules. The guide knows the rules because he, too, walks the narrow path all the days of his life. This is his qualification.'*

After all, who has not thought, after reading endlessly about what goes on in the heads of either mental patients or therapist-cum-psychiatrists; what are they all hoping to achieve if not to transcend the clinical-psychiatric framework?

Truth And The Critic

For some, seeing through one's own psychiatrised mode of perception can come in a flash of insight though effort will precede it. In the UK for example, in fifty years of the journal Existential Analysis, the only paper written by an author who has transcended the clinical-psychiatric framework with finality comes from an ordinary non-professional person who, with no axe to grind, can freely state their conclusions and the work it took to achieve them. I would encourage anyone to read it. Hilary Mantel writes, for example:

> '*The question of whether I was or was not physically ill was still open, but the question of whether I*

> *was mentally ill was closed. It was a non-question. It was not up for debate… I had to save my life.'*

For others it is simpler. Thomas Szasz claimed he never had a belief in mental illness in the first place so he never had one to give up on. However, later in life, reflecting on writing T*he Myth of Mental Illness* at the start of his career, Szasz wrote: *'[…] by alienating me from psychiatry [it] freed me to be myself'*. This suggests it was something he was in fact constantly refining.

Most, however, agonise over their indecision and in their confusion – especially those who like to call themselves 'clinicians' – they confuse others.

Perhaps the most famous example of this is R.D Laing. Laing's need to be seen as what his colleague Esterson called *'[…] psychiatrically respectable'* grew in relation to his need for money, fame and professional recognition. Hence he shifted his position on the existence of mental illness accordingly. I agree with esteemed British existential analysts Naomi and Anthony Stadlen when they dismiss all writing on 'schizophrenia' since Laing's and Esterson's pioneering research into the families of eleven 'schizophrenic' women in *Sanity, Madness and the Family* as '*[…] existentially, a retrogression*'. However, Laing repeatedly betrayed this original epoch-defining work. Toward the end of his life and career he wished to be seen primarily as a conventional psychiatrist. His final book was titled *Wisdom, Madness and Folly: The Ma'king of a Psychiatrist* and in his final paper *God and Psychiatry* he is clear from the start that he is writing *'[…] from the point of view of a practising and theoretical psychiatrist.'*

Laing therefore left a confused legacy. The supposed 'anti-psychiatrist' died loving psychiatry, leaving the implicit non-clinical challenge in his following statement from *Sanity, Madness and the Family* (with Esterson) unmet:

> *'We believe that the shift in point of view that these descriptions both embody and demand has a historical significance no less radical than the shift from a demonological to a clinical viewpoint three hundred years ago.'*

One does not need to conduct research to demonstrate how pervasive this type of confusion is in the helping professions but renowned proponents of the 'psychosocial model' as opposed to the 'medical model' of 'psychosis' felt moved to do so. A study by De Waal, Boyle and Cooke entitled *Trapped in Contradictions: Professionals Accounts of the Concept of Schizophrenia and its Use in Clinical Practice* showed that psychosocial therapists who privately rejected the concept of schizophrenia as a disease-type illness of the mind nonetheless maintained its usage within their practice, especially with patients who were consulting them to be treated for this alleged disease! In a similar paper one of the authors had previously researched psychosocial therapists' experience of working in 'medicalised settings'. In this paper, entitled *Conflict, Compromise and Collusion: Dilemmas for Psychosocially-Oriented Practitioners in the Mental Health System* Cooke and her co-authors identified stress, discomfort, worry, anger and tension within the therapists they interviewed and an associated need to collude and conform with the dominant medicalised view of human problems.

It did not occur to the authors that on top of the ordinary pressures of client-work the extra pressure these practitioners faced is a moral pressure to tell the truth. Nowhere do they say these therapists are lying or fraudulent. Nor do they mention that they or those they interviewed, or indeed anyone, could cultivate a moral position toward psychiatric principles and practices that they maintain unwaveringly.

In fact, the aim of both papers appears to be to confirm how morally uplifted such professionals ought to be feeling working this way in 'medicalised settings'. Both papers were well received.

The supposed predicament these therapists are in mirrors that of the inventor of schizophrenia Eugen Blueler. Blueler did not believe in schizophrenia as a genuine disease but, as above, under pressure he acted as if he did. His solution toward the end of his life was to write a small book titled *Autistic Undisciplined Thinking in Medicine and How to Overcome It* in which he confessed all. Perhaps many similar books are to come.

Modelling Muddle

In the new era of psychiatric critique then, of the few professionals who set foot on a path of psychiatric transcendence the majority become fixated on what I am calling stage one; critique. At this level, by establishing themselves as a 'critic' and surrounding themselves with 'critics', circular discussion sets in within their conferences, papers and books.

This can take many forms. For example, a glance at the current scene reveals a preoccupation on the one hand with the correct *role* of the critic and on the other with the correct *approach* of the critic.

With the former, questions regarding whose critique is valid go back and forth. Is a critique valid only if it originates from within the profession of psychiatry? Or only from outside it? If inside then from which role? Patient or doctor? If outside, must the critic first have been inside? Or is a critique valid only if the critic remained outside refusing to go inside? If the first, from which role? Patient or doctor? If the second, could the critique of the ordinary non-professional person ever surpass either? And so on.

With the latter, conversations similarly go nowhere. In conferences critics talk about the importance of hearing the mental patient's pain rather than taking a medical approach to it (eg). So discussion turns to the merits of different theories or methods of therapy and one feels rather like they are on an introductory counselling course. It is assumed a medical approach is invalid so people talk about building new non-medical approaches to mental disease or its corollary mental health while claiming these are concepts they refute. There is nothing new to these conversations.

A naive observer of this scene may realistically expect to find conventional psychiatrists in one corner and their opponents in the other. In fact, it is now hard to identify either, such is their absorption with one another. More and more, psychiatrists are like their critics and critics are like psychiatrists. What they have in common is that *neither* can walk away from psychiatry.

For example, in their conferences critics recruit psychiatrists to champion their cause. Are they dogged by a subliminal feeling that their own psychiatric emancipation is not complete? Do they feel only a psychiatrist – one who knows the field 'from the inside' – possesses the authority to truly reject it? It seems this way to me. And what would these 'critical' psychiatrists do had they not been rehabilitated by the many critical psychiatry movements now available to them?

Today, the reputable critic of psychiatry has reached, as Freud has put it, a compromise solution. His personal-professional identity is sufficiently fused with the profession of psychiatry to communicate to the conventional psychiatrist he 'knows the score', so to speak, thereby having his 'critique' accepted.

And yet, he is sufficiently self-deceived on this point to communicate to his critical/anti/post psychiatry colleagues that he is not. Thomas Szasz wrote:

> '*Once [a person] becomes a 'mental health consumer' [he] is considered credible only if he praises the system. If he criticizes it, he is dismissed as lacking insight into his 'illness'*.

I would add; so too for the 'mental health worker'. If a 'therapist' rejects the system he is dismissed as lacking insight into other peoples 'illness' or, worse still, of walking away from suffering.

The 'Pre-Psychiatrist'

Now, the ordinary non-professional person need not worry about any of the above. I repeat, with a little courage, anyone can see through the lies of psychiatry. It is only the professional who cannot afford to take the next crucial step and a) reject the principles and practices of psychiatry and b) call for its abolition in their work. Whether in the public realm of writing, public speaking and teaching or in the privacy of client-work. The existential, economic and reputational sacrifices of doing so are too high.

The achievements of Mantel and other non-professionals surpass all expert authors, critics and practitioners past and present. Her description stood out in a professional journal as a straightforward attempt to come to terms with what was being done to her on her own terms and in her own words. As I see it, such individuals are best placed to fulfil the daunting task of the psychotherapist which Esterson outlined above and to act as a guide to the perplexed. For this reason they should not be forgotten.

In *Years of Apprenticeship on the Couch: Fragments of My Training Analysis* psychoanalyst Tilmann Moser's account of his achievements are amateurish in comparison. As an introduction and conclusion to his book, he wrote:

> *'When all is said and done, one's own learning analysis provides the base for one's professional tool kit, with which one then tries to aid other persons suffering from psychic illness'*.

For Moser, a 'full analysis' did not appear to include analysis of habitual deception about the true nature of illness.

Although Erving Goffman in *Asylums* identified and defined the 'pre-patient' phase in the moral career of a psychiatric patient or 'inmate', he did not identify and define its equivalent, the 'pre-psychiatrist' phase in the moral career of those professionals whose aim it is to help him. Perhaps the term 'pre-psychiatrist' should now be introduced to identify and define unexamined psychiatrised or 'pre-psychiatric' modes of perceiving the world and people in it that have not been made explicit through training and personal analysis and which persist. Such making explicit would surely be in the true spirit of an authentic psychotherapy in which one is expected to start with oneself and put oneself into question first.

For the true psychotherapist, psychiatric abolition can only be a personal act. Too often, this foundational principle of the profession is negotiated each time the clinical-psychiatric frame of reference is encountered. This profound lack of faith in the talking cure should not pass unexamined.

Further Problems That Handicap Psychiatric Critics

There are many more ways in which the current scene is de-meaning to the profession of psychotherapy as I understand it and attempt to practice it. Although peripheral to the theme of this paper I will briefly mention two.

We are frequently told for example that psychiatric diagnoses are not valid. But psychiatric diagnoses do have existential and phenomenological validity. They refer concretely to identifiable patterns of behaviour and experience that can be observed. Although, more precisely, they are patterns of negation of behaviour and experience. But they are not diseases.

We are also frequently told a medical approach to psychiatric diagnoses is not valid. The implication is that some other model would be. But only by applying the medical model can one see there is no illness to treat. The first rule of medicine to ascertain whether there is or is not disease! If mental illness does not exist it does not make sense to take any sort of approach to 'it'. Neither does it make sense to build any sort of model of 'it' or mental treatment for 'it'. Or, for that matter, of 'mental health' for if mental illness cannot be demonstrated neither can mental health. Furthermore, in a truly autonomous psychotherapy it is the client who is approaching the therapist and not the other way round. Hence, the whole idea of 'taking an approach' is confused in many ways.

Thus, I am using the word 'de-mean' here and throughout this paper in two ways. Firstly, to denote emptying the profession of its rich meaning. Secondly, to denote robbing the professional psychotherapist of their dignity and worth.

Refreshing the Parts Other Critics of Psychiatry Cannot Reach: Thomas Szasz?

Behind the supposed perplexities surrounding the correct role and approach of the critic lies a question: '*What defines an honourable critic of psychiatry?*'

Although I do not want to sound arrogant, I believe I know the answer. Indeed, I believe that most professionals know it too, albeit they do not want to admit it, or as Freud said, and as I showed above, they repress it. And the repressed, as Freud has put it, invariably returns.

As I see it, the very idea of an honourable critic of psychiatry is itself an oxymoron. This is not solely my point of view but I endorse it wholeheartedly. Like Thomas Szasz, I believe that by selectively criticising the treatment of mental illness and promoting alternative treatments for 'it' and new approaches to 'it' critics validate 'its' reality. Szasz called this the 'fatal flaw' of the psychiatric critic. For this reason psychiatric power drags on. The more it is criticised the more powerful it becomes. No longer limited to psychiatrists it is increasingly covert and subtle, pervading all of society through the infinite guises in which 'mental health professionals' now appear.

Unlike many, I believe Szasz is a good model for those in training. He had a strong faith in humanity and often wrote that deep in their hearts most people know that psychiatric explanations and interventions are fatally flawed. He would have agreed with the view put forward in this paper that, in the final analysis, psychiatric abolition must be a personal act. Herein lies the path of the dignified critic.

Conclusion: The Forgotten Element in Psychiatric Critique: Self-Confrontation

There cannot be one universally valid 'approach' to transcending the clinical-psychiatric framework that could be prescribed by any 'critical psychiatry' professional or organisation. The source of a person's psychiatrisation must be searched for deep within their own life situation. It is a personal venture that no one else can undertake for one vicariously and then prescribe as a readymade solution.

If a guide is needed in this venture, it is surely one who is themselves successfully freed of the terrors of breaking psychiatric taboos who will not become a collusive complement to the other's fear. In *The Self and Others*, at the peak of his genius, R. D. Laing wrote:

> *'It is in terms of a basic frustration to the self's search for collusive complements for its false identities that Freud's dictum that analysis should be conducted under conditions of maximal frustration takes on its most cogent meaning.'*

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